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REPRODUCTIVE JUSTICE:

A FRAMEWORK FOR ABORTION LAW REFORM

KATE GALLOWAY* AND JEMIMA MCGRATH**

I. INTRODUCTION

Australia has seen a number of efforts at reform of abortion laws in recent years. Jurisdictions such as Tasmania, Victoria, the Australian Capital Territory, and the Northern Territory have decriminalised abortion entirely, and other states such as South Australia and Western Australia have made efforts to reform abortion law without complete decriminalisation. At the other end of the spectrum, Queensland and New South Wales legislation still lists abortion as a criminal offence, and although this is mitigated by case law, there has been no successful attempt to reform abortion law in these jurisdictions. This article canvasses the current review of Queensland's abortion laws.

Revision of the Queensland *Criminal Code* in 1997, the culmination of a protracted and highly politicised process, had failed to mention abortion law reform. Queensland's Women and the Criminal Code Taskforce recommended repealing the abortion laws,¹ but these recommendations were not implemented. In Queensland, abortion law reform has simmered in the political background.² Most recently, however, following the withdrawal of a private member's Bill presented to the Queensland Parliament in 2016,³ the newly installed Palaszczuk government referred the question of reform of Queensland's termination laws to the Queensland Law Reform Commission ('QLRC').⁴

The QLRC has now handed down its report,⁵ and the Government has accepted all 28 recommendations. It is anticipated that a Bill will be put to the Queensland Parliament before the end of 2018. In the lead up to the Bill, it is useful to consider the framing of the contemporary debate about abortion law reform in Australia in particular, in light of its contentious nature.

The QLRC inquiry consultation questions opened by asking 'Who should be permitted to perform, or assist in performing, lawful terminations of pregnancy?' While this question illustrates broader and traditional legal approaches to the regulation of abortion, it was however, question two that provided the crux of law reform efforts for pro-choice campaigners: 'Should a woman be criminally responsible for the termination of her own pregnancy?' If the inquiry had started with this second question, and had answered 'no',

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¹ Taskforce on Women and the Criminal Code, Parliament of Queensland, *Report of the Taskforce on Women and the Criminal Code* (2000)

² See, eg, discussion in Katherine Kerr, 'Queensland Abortion Laws: Criminalising One in Three Women' (2014) 14(2) *QUT Law Review* 15, doi: <https://doi.org/10.5204/qutlr.v14i2.540>.

³ Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 (Qld); Health (Abortion Law Reform) Amendment Bill 2016 (Qld).

⁴ Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws Consultation Paper*, WP No 76 (December 2017) ('Consultation Paper').

⁵ Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws Report No 76*, June 2018.

then based on principles of reproductive justice the answers to remaining 20 questions would have become clear.

Broadly speaking, the QLRC consultation questions canvassed who should be permitted to perform or assist in performing terminations, the limits and grounds of terminations including requirements for counselling of women and medical practitioners' consultation, questions of conscientious objection, safe access zones, and data collection. These matters were addressed in the recommendations, which fell under five broad categories:

- abortion should generally be treated as a health matter;
- women's autonomy and health should be promoted;
- Queensland laws should align with contemporary international human rights obligations;
- Queensland laws should be consistent with contemporary clinical practice; and
- Queensland laws should be broadly consistent with other Australian jurisdictions that have modernised their abortion laws

Abortion is a touchstone for social, ethical, and religious norms. It is these norms that have informed the law and that continue to generate such heated debate. On the other hand, invoking criminal law to sanction both women and their treating doctors fails to recognise women's agency as equal citizens. Further, and in any event, criminalisation of abortion fails to address the broader contexts of women's lives that affect their reproductive choices. This article uses the framework of questions in the QLRC consultation paper to review—yet again—the ongoing need for abortion law reform in Queensland specifically, but through analogy, in Australia generally. While answering the QLRC questions, we frame our inquiry around empowering women's self-determination to make decisions about their reproductive health as a hallmark of their equality as citizens. Accordingly, we first address the underlying question of criminal responsibility for pregnancy termination as a question of reproductive rights, then analyse the broader social contexts of termination services necessary to deliver reproductive justice. These demand attention to matters such as the effect of service location, age, access to qualified health professionals, privacy, and gender diversity.

At the outset, we recognise diversity in gender amongst those capable of becoming pregnant. We use the term 'woman' throughout this article, but we acknowledge the experiences of those who do not identify as female. It follows that the law surrounding termination of pregnancy should be framed to ensure that it accommodates reproductive justice for all who are pregnant.

II. CRIMINAL RESPONSIBILITY FOR PREGNANCY TERMINATION

In the liberal tradition embedded within Australian systems of governance, the autonomy of individuals is paramount. Autonomy manifests as various freedoms for the individual to determine their best life with minimal state intrusion. Yet the state itself determines the competence of individuals to exercise their freedoms. Paradoxically, the state intervenes in the most intimate of circumstances to constrain individual freedom yet in other areas is slow to afford protection against bodily incursions. This is notably the case in circumstances involving sex and gender.⁶

⁶ Frances E Olsen, 'The Family and the Market: A Study of Ideology and Legal Reform' (1983) 96(7) *The Harvard Law Review* 1497.

Traditionally, and in accordance with social norms derived from a patriarchal order, the state has upheld a social and legal paradox whereby women are both autonomous citizens equal with men, while at the same time are *incompetent* to make autonomous choices about various aspects of their lives—especially their bodies.

The criminalisation of pregnancy termination is one such example. Underpinning the crime of procuring the termination of one's own pregnancy is the assumption of women's incompetence to exercise self-determination and autonomy in decisions about her bodily integrity.⁷ Once pregnant, the law constructs 'woman' as a different being⁸ and regulates her body accordingly. Morris and Nott point out that: 'English law has denied personhood to the foetus but tends to treat pregnant women as being in conflict, ie woman against foetus'.⁹ This opposition is recognised in arguments about the gestational stage permitted for termination, which assume the priority of a foetus over the woman.¹⁰

Opposition is implicitly embedded also where the interests and autonomy of the woman are considered as secondary to the interests of the state and other actors. Thus, the QLRC's consultation paper prioritises the question of who should be permitted to perform or assist in performing an abortion¹¹—rather than commencing with the question of whether a woman should suffer criminal sanction in making a decision about her own body.

A. Decriminalisation and Reproductive Rights

Abortion can be considered one aspect of women's reproductive rights. To the extent that the law provides criminal sanction for a woman who procures termination of her pregnancy, such laws breach women's reproductive rights as well as her bodily autonomy.

Helpfully, London outlines four human rights principles underlying reproductive rights:

1. Choice of whether and when to bear a child;
2. Privacy of personal decisions about sexual intimacy and childbearing;
3. Freedom from governmental interference in medical decisions made by an individual with her doctor; and
4. Autonomy exercised through the freedom to make decisions about one's body.¹²

While not enshrined in law, the Queensland Parliamentary Committee on Surrogacy made recommendations based upon the concept of rights or freedoms to choose to have a child.¹³ Although couched in terms of 'parents' rather than women, this example illustrates the capacity of the law to comprehend the notion of reproductive rights.

On a reproductive rights basis, the core question to be answered by the QLRC consultation should therefore have been whether a woman should suffer criminal sanction for procuring her own abortion. The answer is that a woman should *not* be criminally responsible for the

⁷ See, eg, Kerr, above n 2.

⁸ Anne Morris and Susan Nott 'The Law's Engagement with Pregnancy' in Jo Bridgeman and Susan Millns (eds) *Law and Body Politics: Regulating the Female Body* (Dartmouth, 1995) 53, 55.

⁹ Ibid 56.

¹⁰ See, eg, ibid 42, [146].

¹¹ Consultation Paper, above n 4, v, Questions 1 and 2.

¹² Sarah London, 'Reproductive Justice: Developing a Lawyering Model' (2011) 13 *Berkeley Journal of African American Law and Policy* 71, 76.

¹³ Queensland Parliament, *Investigation into Altruistic Surrogacy Committee Report* (2008), 18, 20. The Committee had been established to 'investigate and report to the Parliament on the possible decriminalisation and regulation of altruistic surrogacy in Queensland'. The recommendations resulted in the enactment of the *Surrogacy Act 2010* (Qld).

termination of her own pregnancy. The remaining questions in the QLRC consultation would then have become subsidiary to the woman's right to be considered an agentic individual at law.

B. *Who Might Lawfully Perform Abortions and When*

Once the law accepts the woman as an autonomous citizen responsible for her bodily integrity, the question of abortion becomes a medical rather than a legal question.

On the assumption that termination of pregnancy, whether surgical or medical, is a medical procedure, then subject to clinical recommendation as to expertise, it becomes subject to the same regulation as other medical procedures. This is a clinical question rather than one of law and does not therefore require specific provision within the criminal law which otherwise deals with assault and offences by unqualified persons.

Further, clinical guidelines informed by medical ethics are best placed to dictate the circumstances of a termination, including as to:

1. Gestational stage;
2. Woman's health;
3. Foetal viability;
4. Practitioner consultation; and
5. Whether the termination is undertaken medically or surgically.

Where medical practice is guided by norms of decision-making in the patient's best interests and of harm-minimisation, it is appropriate for evidence-based clinical guidelines to inform practice, rather than the criminal law.¹⁴

III. REPRODUCTIVE JUSTICE

Merely enacting reproductive rights—and thus formal equality—is not, however, sufficient to achieve reproductive *justice*. Therefore, analysis of the extent to which the law might support reproductive rights must consider the effect of power relations and differential resources on women's ability to access abortion services.¹⁵ For example, one consistent effect of criminalisation of abortion is the likely availability of safe medical services to those who can pay, and the exclusion from safe medical services of those who cannot afford them.¹⁶

¹⁴ See eg, M Berer, 'Making Abortions Safe: A Matter of Good Public Health Policy and Practice' (2000) 78(5) *Bulletin of the World Health Organisation* 580; David A Grimes et al, 'Unsafe Abortion: The Preventable Pandemic' (2006) 368 *The Lancet* 1908, doi: [https://doi.org/10.1016/S0140-6736\(06\)69481-6](https://doi.org/10.1016/S0140-6736(06)69481-6); Lachlan J de Crespigny and Julian Savelescu, 'Abortion: Time to Clarify Australia's Confusing Laws' (2004) 181(4) *Medical Journal of Australia* 201.

¹⁵ London, above n 12, 77. See also Barbara Baird, 'Decriminalization and Women's Access to Abortion in Australia' (2017) 19(1) *Health and Human Rights* 197; L A Keogh et al, 'Intended and Unintended Consequences of Abortion Law Reform: Perspectives of Abortion Experts in Victoria, Australia' (2016) *Journal of Family Planning and Reproductive Health Care* doi: 10.1136/jfprhc-2016-101541.

¹⁶ See, eg, Victorian Law Reform Commission, 'Law of Abortion' Final Report 15 (March 2008), Appendix One, [A28]; Caroline de Moel-Mandel and Julia M Shelley, 'The Legal and Nonlegal Barriers to Abortion Access in Australia: A Review of the Evidence' (2017) 22(2) *The European Journal of Contraception & Reproductive Health Care* 114, DOI: 10.1080/13625187.2016.1276162.

Power relations and resources are relevant not only in achieving equality of access to safe abortion, but also in considering the context within which a woman decides to terminate her pregnancy.

The socio-economic determinants of health are well rehearsed.¹⁷ Where abortion is treated as a health issue, a woman's socio-economic circumstances therefore become relevant in making decisions about whether to proceed with a pregnancy. For the law to delimit circumstances that warrant termination¹⁸ will inevitably fail to comprehend the woman's experience of her circumstances. By contrast, as a medical or clinical matter, the health practitioner is best placed to advise based on what is appropriate to the woman in her circumstances.

Of note, in the case of termination of pregnancy, it is ill-conceived to make assumptions about socio-economic determinants of women's health based upon standard demographic indicators such as place of domicile or household income. A woman whose outward appearance and location of her domicile might give the impression of access to financial means. However, as a consequence of gendered power dynamics within the household, she may not have access to sufficient economic resources to support a child, or to bear the costs of a termination.

Specific to the reform of the law of termination of pregnancy, a framework of reproductive justice requires consideration of the effect of the law on the availability of relevant medical services to all women, including with reference to:

1. Location of services;
2. Age and therefore capacity to give consent to medical or surgical procedures;
3. Access to relevantly qualified medical and allied health professionals; and
4. Privacy of service delivery.

A. Location of Services

As observed in the QLRC Consultation Paper, the majority of abortion services in Queensland are carried out by private providers.¹⁹ Consequently, terminations are relatively easy to access in many metropolitan areas but are increasingly difficult to access in regional and in particular, in remote areas. This is now a real issue for Tasmanian women, who have recently lost access to terminations in that state following the closure of the sole (private) provider, and is also an issue across regional Australia. Abortion may be currently permitted under Queensland law, but the current system, as it does also elsewhere in Australia, discriminates indirectly between metropolitan and regional women.²⁰

Decriminalisation of terminations so that they become a health matter will facilitate provision within the existing health network including to regional and remote women. This change in focus will bring medical resources within the reach of all women.

B. Age

While location is one issue affecting reproductive justice, so too is age—through the question of capacity to give informed consent. As the Consultation Paper points out,²¹

¹⁷ See, eg, Australian Institute of Health and Welfare, *Australia's Health 2016*, Chapter 4 'Determinants of Health' <<https://www.aihw.gov.au/reports/australias-health/australias-health-2016/contents/determinants>>.

¹⁸ Such as those discussed in the Consultation Paper, above n 4 44–7.

¹⁹ Consultation Paper, above n 4, 20.

²⁰ de Moel-Mandel and Shelley, above n 16.

²¹ Consultation Paper, above n 4, 9.

minors may be deemed capable of giving consent to a medical procedure. Where they are not, the Court may be asked to invoke its *parens patriae* jurisdiction to authorise the decision.

In Queensland, the decision of *Central Queensland Hospital and Health Service v Q*²² highlights the need for reform in this area. Although the 12-year-old girl seeking a termination of her pregnancy was in this case deemed capable of consenting to the procedure, the relevant authorities sought the imprimatur of the Court. The Court ordered that the girl's father be included in the decision-making—against the girl's express wishes that the father not be told.²³

Where abortion remains illegal, obtaining a court order protects decisions of treating doctors against possible criminal action. By contrast, surgery such as a tonsillectomy, or administration of drugs such as steroids or cancer drugs would not require the court's permission. Involvement of the Court in this case—arising because of the possibility of criminal sanctions—adversely affected the girl, delayed her treatment and her suffering, and interfered with her bodily autonomy even as she was deemed to have capacity for self-determination.

Decriminalisation of abortion, coupled with a therapeutic approach and bounded by the norms and laws concerning informed patient consent and self-determination, would necessarily avoid Court intervention in such circumstances.

C. Access to Relevantly Qualified Professionals

Related to location of services is access to relevantly qualified professionals. In terms of reproductive justice, this requires considering contexts beyond health services per se, to the professional mix required to ensure equity of access to abortion services.

Notably, the Consultation Paper questions the need for counselling services as a prerequisite to obtaining a lawful termination. A health-based approach rather than a legal approach offers a different way of understanding the role of and need for counselling. The law need have no role in mandating counselling as a pre-requisite. Instead, counselling would be a component of ensuring patient autonomy to make decisions about her own body, free from coercion that might occur within her social context. This offers a model of patient care as well as satisfying legal requirements of consent to a procedure. In other words, provision of relevantly qualified counsellors as integral to the process of offering advice to women seeking a termination, speaks to informed consent but, as with any other medical procedure, need not be mandated as an element of lawfulness.

In attempting to paint a pro-choice approach to abortion as anti-women, some (effectively) suggest that abortion is a patriarchal tool designed to prevent women from exercising reproductive freedom—ie freedom to give birth. Abortion is indeed a tool involved in women's reproductive freedom. It might liberate women from the burdens of bearing, delivering, and raising a child as an expression of her bodily autonomy—but it might also be used as a tool of oppression where that woman desires to go ahead with her pregnancy.

The possibility of abortion being used coercively is, however, no reason to criminalise the practice. Instead, it is reason to ensure that women are in a position to give free, prior, and

²² [2016] QSC 89 (26 Apr 2016).

²³ Heather Douglas and Caroline de Costa, 'Time to Repeal Outdated Abortion Laws in New South Wales and Queensland' (2016) 205(8) *Medical Journal of Australia* 1, doi: 10.5694/mja16.00807.

informed consent to the procedure upon obtaining qualified advice, including counselling. In particular, women experiencing pressure, domination, or violence need the opportunity to work through their concerns until they are able to make an informed decision. That decision may well reflect her coercive circumstances, but counselling offers the opportunity to make the decision on her own terms in light of her social context.

For this reason, the law should recognise, and clinical guidelines should reflect, that in light of gendered power dynamics and socio-economic determinants, consent to termination will in most circumstances be ‘informed’ where the woman has been afforded access to qualified counselling in reaching her decision.

D. Conscientious Objection

It is one thing to decriminalise abortion, but quite another to require health practitioners to provide those services. In such a ethically-charged issue there is a balance to be achieved between the expression of the conscientious concerns of health providers, and the autonomy of women seeking reproductive services.

Reproductive justice inevitably demands provision of public health services, ensuring equality of access for all women.²⁴ This particularly an issue for women in remote and regional areas, where there is a far smaller pool of relevantly qualified professionals. In such circumstances, if a health practitioner conscientiously objects to delivery of reproductive health services, a woman may have no practical alternative.

In terms of an individual’s health practice however, in accordance with the underlying principle of women’s agency over their bodily autonomy and in particular in the case of emergency, there are four constraints on the exercise of conscientious objection.

The first of these involves an emergency where the woman’s life is in danger, or where there is a risk of grave harm to the woman. In these circumstances, a health care provider should not be entitled to withhold reproductive services, including a termination, based on conscientious objection. While this shifts the balance of autonomy from the health care provider to the woman, the imminent danger to the woman justifies the imposition on the health care provider.

Secondly, to address the inequality of access to reproductive services experienced by remote and regional women, a health care provider should not withhold reproductive services, including a termination, based on conscientious objection where there are no other geographically proximate services.²⁵ Again, this is a shift in the autonomy of the health care provider to the woman, recognising the potentially greater harm to the woman from denying care. In practical terms, this principle is likely to require the state to ensure adequate staffing levels of appropriately qualified professionals who are able to provide these services.

²⁴ See, eg, discussion in Ronli Sifris, ‘The Legal and Factual Status of Abortion in Australia’ (2013) 38(2) *Alternative Law Journal* 108.

²⁵ See, eg, Keogh et al, above n 15; de Moel-Mandel and Shelley, above n 16; Mridula Shankar et al, ‘Access, Equity and Costs of Induced Abortion Services in Australia: A Cross-sectional Study’ (2017) 41(3) *Australia and New Zealand Journal of Public Health* 309, doi: 10.1111/1753-6405.12641; Ronli Sifris, ‘A Woman’s Right to Choose’ in Paula Gerber and Melissa Castan (eds) *Contemporary Human Rights Issues in Australia* (Thomson Reuters, 2013) 251, 25; Victorian Rural Women’s Access to Family Planning Services Report (2012) <<http://whv.org.au/static/files/assets/c6ba5133/Victorian-rural-womens-access-to-family-planning-services-survey-report-August-2012.pdf>>.

Australian jurisdictions where abortion is legal have provided for conscientious objection,²⁶ predominantly in non-emergency situations—although they do not distinguish between objection to provision of direct and ancillary services. There is some debate in jurisdictions that require practitioners to perform emergency abortions regardless of conscience, most notably in Victoria, where the Catholic Church threatened to close its hospitals because of the conscientious objection clause.²⁷ Such legislative provisions are, however, similar enough to equivalent English provisions that the test of proximity set out by the House of Lords might be persuasive in Australian jurisdictions. The House of Lords applied this test in considering who was entitled to conscientiously object under the *Abortion Act 1967* (UK). It found that only those participating in the procedure had sufficient proximity to be excused based on conscientious objection.²⁸ On this rationale, medical receptionists, counsellors, or other ancillary staff would not have grounds for conscientious objection to providing information, for example, to a woman seeking a termination.

Through the lens of reproductive justice, the question of conscientious objection might be addressed indirectly. Thus, a health care provider who conscientiously objects to providing reproductive services whether direct or ancillary, and including termination, should refer the woman, in a clinically timely way, to another geographically proximate health provider that will provide the relevant service.²⁹ A conscientious objector should not be permitted to refuse to refer a woman based on their conscientious objection. This provides a balance between recognising the imposition on the conscientious objector, while respecting the woman's right to choose. Providing for the clinical context reinforces the health-based approach to abortion, and the professional responsibilities of care.

E. Privacy

A component of reproductive rights, privacy in abortion law reform is relevant in a number of ways, the first two of which are dealt with above:

1. privacy from state intervention;
2. privacy from others influencing the decision she makes in consultation with her health care providers;
3. privacy from grandstanding or harassment in the vicinity of the clinic; and
4. privacy from dissemination of her name, image, or personal details in connection with any reproductive service.

In respect of the third and fourth of these aspects of privacy, in the interests of effectively providing health care services to women seeking a termination, it should be unlawful to harass, intimidate or obstruct both a woman who is considering, or who has undergone, a termination of pregnancy; or a person who performs or assists, or who has performed or assisted in performing, a lawful termination of pregnancy.

²⁶ Northern Territory, South Australia, Tasmania, Victoria, Western Australia. See discussion in, eg, Victorian Law Reform Submission, above, n 16. The Australian Medical Association did not support conscientious objection (at p114).

²⁷ Anna O'Rourke, Lachlan de Crespigny and Amanda Pyman, 'Abortion and Conscientious Objection: The New Battleground' (2012) 38(3) *Monash University Law Review* 87.

²⁸ See *Janaway v Salford AHA* [1988] 3 All ER 1079.

²⁹ See, eg, *Termination of Pregnancy Law Reform Act 2017* (NT), s11.

In recognition that decriminalisation of pregnancy termination is not of itself sufficient to provide access for women needing termination services, Victoria, Tasmania and the ACT³⁰ have each enacted safe access zone legislation as a means of supporting women's access to reproductive services.

Rather than establish the extent of a safe access zone in legislation, ministerial discretion is a flexible means of dealing with strategies from time to time of those who seek to harass, intimidate, or obstruct the provision or receiving of reproductive services.

A reproductive justice approach to regulating abortion provides guidance on how to determine the extent of the safe access zone. Although safe access zones should through their operation *protect* women and those carrying out the relevant services, ministerial discretion to enact a safe access zone would recalibrate the power imbalance between those seeking to harass, intimidate, or obstruct, and the women involved.³¹ The rationale is that failing to enact a safe access zone allows for circumstances that will prevent women from exercising their bodily autonomy.

Those arguing against safe access zones cite their right to free expression. What this claim fails to acknowledge is the vulnerability of those seeking a termination, and the relative power wielded by those seeking free expression. The extent of the safe access zone must therefore reflect a balance between the harm done to the women in accessing health care services, and the intrusion into the lives of those prevented from carrying out their activities within that zone. The size of the zone would therefore become the area reasonably necessary to ensure equity of access to reproductive services.

The types of activities constrained within the zone also requires balancing competing claims. A principled approach to determining prohibited activities would aim at any activity designed to deter a woman from seeking reproductive health care at the facility associated with that safe access zone or disseminating a view on reproduction. This approach recognises that women will receive the best clinical care, including full information on which to make her decision. It is not the purview of the general public to intervene in attempting to convince a woman about her healthcare. In prosecuting her autonomy, a woman is entitled to access health services free from unsolicited attempts to convince her otherwise. Those outside the relevant facility are not entitled to air their views in light of the availability of qualified health care expertise within the facility. In light of the distressing nature of such information and the public context within which it is delivered, such activity should be constrained by law.

As a feature of reproductive justice, the privacy of women using or approaching the facilities extends to dissemination of their images, names, and personal details electronically or otherwise. Creation or dissemination of such details should constitute an offence. This is no more than what is already provided for in the *Privacy Act 1988* (Cth), for example, in relation to sensitive information.

Ensuring a safe work environment for those providing health care services requires the same protection. Such provisions will also ensure that health care service provider staff can

³⁰ See, eg, Heather Douglas and Katherine Kerr, 'Abortion, Law Reform and the Context of Decisionmaking' (2016) 25(1) *Griffith Law Review* 129, doi: 10.1080/10383441.2016.1201882.

³¹ See, eg, Ronli Sifris, 'State by State, "Safe Access Zones" Around Clinics are Shielding Women from Abortion Protesters' *The Conversation* (30 November 2015) <<https://theconversation.com/state-by-state-safe-access-zones-around-clinics-are-shielding-women-from-abortion-protesters-51407>>.

continue to carry out their work unmolested, ensuring continuity of service for women who need it.

F. Collection of Data about Terminations of Pregnancy

Ensuring effective provision of reproductive services throughout the state requires data concerning the need for and delivery of such services. It is therefore appropriate to provide for collection of patient information but only where appropriate safeguards are incorporated. For example, anonymisation of patient records is imperative to ensure privacy both in terms of the possibility of reconstructing de-identified information, but also to protect against the possibility of unauthorised or unintended leaks.

Any data collection system must also cater for the likelihood of identification of patients in regional and remote areas. Such patients are likely to be readily identifiable with only minimal demographic information.

IV. CONCLUSION

While there have been advances in the law surrounding termination of pregnancy in other Australian jurisdictions, the fight for lawful access to safe abortion services in Queensland is ongoing, even in the lead up to the introduction of a reform Bill. Hard-won concessions are always at risk, as evidenced by the decision to prosecute Tegan Leach and her partner in 2010.³² Further, the ongoing referral of abortion laws to various committee and law reform processes has so far failed to clarify or to advance the law in Queensland. Such drawn-out processes have the appearance of a lack of political will to address the issue head on.

While there is a myriad of complex questions that are posited for examination through a legal lens, we suggest instead exploration of the notion of women's reproductive rights, and reproductive justice as an alternative means of assessing the role of the law. Such a framework recognises the social context of pregnancy and termination and seeks to uphold women's agency within that context. We suggest that reproductive justice affords a more positive—and a less punitive—approach to resolving the law's involvement in what should more properly be regarded as a question of women's health.

³² *R v Brennan and Leach* [2010] QDC 329.